

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **ROBERT J. GUERRA, M.D.**

4 Holder of License No. **10189**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-03-0130B

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on April 14, 2005. Robert J. Guerra, M.D., ("Respondent") appeared before the Board
9 with legal counsel Dan Cavett for a formal interview pursuant to the authority vested in
10 the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of
11 fact, conclusions of law and order after due consideration of the facts and law applicable
12 to this matter.
13

14 **FINDINGS OF FACT**

15 1. The Board is the duly constituted authority for the regulation and control of
16 the practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of License No. 10189 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-03-0130B after receiving notification
20 of a medical malpractice settlement involving Respondent's care and treatment of a 57
21 year-old male patient ("AO").

22 4. AO presented to his family physician ("PCP") reporting changes in bowel
23 habits and blood in the stool. On July 20, 2000 a gastroenterologist
24 ("Gastroenterologist") performed a colonoscopy on AO at Tucson Medical Center and
25 found a tumor at the junction of the rectal sigmoid at 18 cm from the anal verge.
Gastroenterologist contacted PCP directly and reported his findings. PCP advised AO to

1 come to his office and arranged for same day admission to Carondelet St. Mary's
2 Hospital and a surgical consultation with Respondent. PCP understood from
3 Gastroenterologist that the cancer was in the cecum and advised Respondent of this
4 finding. Respondent agreed to perform the surgery the next day. In his progress note
5 PCP wrote the cancer was in the cecum and dictated a history and physical indicating the
6 lesion was in the cecum. PCP then ordered a chest x-ray and indicated in the diagnosis
7 there was cecal cancer. When Respondent arrived at the hospital to perform the surgery
8 the nursing staff advised him they had made repeated unsuccessful attempts to obtain
9 the colonoscopy report. Respondent decided to proceed with the surgery without
10 reviewing the report based on his previous history working with PCP.

11 5. At the formal interview Respondent testified that PCP was a former practice
12 partner with whom he had shared an office for over 18 years and had consulted with on
13 thousands of patients. Respondent testified PCP was a good and caring physician who
14 unfailingly gave accurate information regarding patients he referred. Respondent
15 testified AO had undergone a colonoscopy for rectal bleeding and bowel habit change.
16 PCP then received a verbal report from Gastroenterologist that PCP interpreted as
17 indicating a cecal tumor had been found. AO then returned to PCP with a photograph of
18 the lesion and was admitted to the hospital with the plan to complete the workup and
19 proceed with surgical resection. Respondent stated that AO underwent a standard
20 preoperative workup in addition to CT scanning of the abdomen and pelvis to determine if
21 there was tumor spread. The CT scan did not provide any information regarding the
22 location of the tumor.

23 6. Respondent testified he saw AO the day after his admission (the day of
24 surgery) and obtained a history and evaluated him physically. Respondent testified he
25 reviewed the in-patient chart and the various studies that had been performed, including

1 the photograph from the colonoscopy. Respondent testified all notes from the attending
2 physician, the nurses and the anesthesia personnel involved in the case indicated the
3 presence of a colonic lesion located in the cecum. Respondent noted this included the
4 face sheet, request for studies, history and physical, and the consent form signed by AO.

5 7. Respondent testified he discussed the diagnosis, his proposed treatment
6 plan, and the risks and benefits of the operation with AO and his wife. AO agreed to
7 proceed. Respondent stated the nurse in the holding area told him she had made
8 several unsuccessful attempts to obtain a written report of the colonoscopy and to
9 contact Gastroenterologist. Respondent testified when his attempt to obtain the
10 descriptive note also failed he called PCP to let him know he did not have the written
11 report and had been unable to contact Gastroenterologist. Respondent testified his main
12 concern was to be sure no other abnormalities were noted on the colonoscopic
13 examination. Respondent testified he was again assured he was dealing only with a
14 cecal tumor, probably a cancer, in the estimation of Gastroenterologist.

15 8. Respondent testified AO was very anxious, hospitalized and adequately
16 prepared for the operation. Respondent testified the operation was obviously necessary
17 and there was a lot of confirmatory evidence in the chart regarding the location and
18 character of the tumor. Respondent testified on this basis, he decided to proceed.
19 Respondent testified he explored as is his custom through a right upper abdominal
20 incision horizontally, one similar to that used for appendectomy. Respondent testified his
21 initial palpation of the bowel and exploration was negative and he proceeded to mobilize
22 and expose the cecum. Respondent noted in these cases it is not unusual to have
23 difficulty feeling the lesion. Respondent noted sometimes he actually has the
24 endoscopist mark the bowel with ink to assist in determining the exact indication of the
25 tumor.

1 9. Respondent testified there was a palpable abnormality in the cecum and he
2 proceeded with the resection. Respondent testified the specimen was opened in the
3 operating room to assure that the resection and the margin of normal tissue removed was
4 adequate for the case, but there was no tumor in the lumen of the bowel. Respondent
5 testified his first thought was he had removed an inadequate length of colon and the
6 tumor was still present more proximal or higher in the colon. Respondent testified he
7 then lengthened the incision and reaccessed the colon. Respondent noted he was able
8 to palpate some induration in the pelvis with nothing else palpable in the remaining
9 colonic tissue.

10 10. Respondent testified he then made a horizontal incision and a lower
11 abdominal vertical incision to give him better access to the pelvis. Respondent noted the
12 sigmoid colon was directly mobilized from the sacrum after which he was able to clearly
13 feel a couple of tumors in the rectum. Respondent testified he removed these with the
14 normal margin of tissue and the specimen was opened in the operating room and the two
15 lesions were confirmed by inspection. Respondent stated the more proximal lesion was
16 noted by pathologic examination to be a typical colorectal cancer with the second lesion
17 being a rectal carcinoid tumor.

18 11. Respondent testified he believed a series of unfortunate circumstances led
19 to the well intentioned mistake of removing tissue that did not have to be removed.
20 Respondent testified he was very much aware that AO suffered the consequence of this
21 mistake and he is truly sorry for that. Respondent stated the repercussions of his
22 mistake have severely affected him, his family, and his professional practice.
23 Respondent testified he has been a surgeon for twenty-five years and has done
24 hundreds of colonic operations with nothing like this happening before or since.
25

1 Respondent noted he had modified his practice to avoid the possibility of a repeat error of
2 this type.

3 12. Respondent was asked to clarify what reports PCP had received from
4 Gastroenterologist regarding the results of AO's colonoscopy. Respondent testified he
5 had seen various allusions as to what happened, but he read there was a written report,
6 a photograph, and an oral report. Respondent testified he cannot say exactly what
7 transpired, although when he and PCP spoke, PCP had spoken to Gastroenterologist.
8 Respondent stated PCP verbally told him AO's tumor was present in the cecum and was
9 most likely cancer. Respondent was asked what he knew at the time of surgery about
10 any communication between Gastroenterologist and PCP. Respondent testified AO had
11 brought the photographs to PCP after the colonoscopy, but he did not know whether PCP
12 had the written report. Respondent testified AO had the colonoscopy at a hospital and
13 when he recovered from sedation presented to PCP's office. At that point, PCP admitted
14 AO to another hospital and called Respondent. Respondent testified he did not see AO
15 on the day of admission, just on the day of surgery. Respondent noted that he had
16 nothing in writing regarding Gastroenterologist's report on the colonoscopy.

17 13. Respondent was asked why his attempts to get the colonoscopy report prior
18 to surgery were unsuccessful. Respondent testified he was not sure, but he had called
19 the hospital and accessed the dictation system in an attempt to listen to the dictation.
20 Respondent stated he was not able to call up the dictation and is not sure if it had not yet
21 been dictated or was in the process of being dictated, but he could not call it up.
22 Respondent was asked if he tried to communicate directly with Gastroenterologist.
23 Respondent said several unsuccessful attempts were made to reach Gastroenterologist.

24 14. Respondent confirmed that even without written documentation or direct
25 communication with Gastroenterologist he elected to move forward with the surgery.

1 Respondent was asked if he ran the bowel before he started the procedure. Respondent
2 testified to him "run the bowel" means you look at the small intestine, look at the colon
3 and check the liver and so on, and he did do that. Respondent testified he palpated the
4 structures in the abdominal cavity and palpated the colon. Respondent was asked what
5 his thoughts were when the specimen was opened and, because there was no obvious
6 tumor, he placed a call to Gastroenterologist who informed him the lesion was actually on
7 endoscopy in the sigmoid colon. Respondent testified when he took out the cecum and
8 found there was no tumor his initial thought was he had not taken enough length and that
9 is why he needed to make a bigger incision and get a better feel for things. Respondent
10 noted by the time Gastroenterologist called him back, he was well into the resection.

11 15. Respondent was asked what he would have done had Gastroenterologist
12 not called him back. Respondent testified he had already made a decision to move
13 forward and was pretty sure the tumor was in the rectum. Respondent was asked to
14 clarify how, since he had gone from the cecum to the opposite side, he was now sure the
15 tumor was in the rectum without having spoken with Gastroenterologist. Respondent
16 testified he did not feel the tumor the first time for a number of reasons: 1) it was limited
17 access, up high through a small incision in a big man; and 2) the tumor was outside the
18 peritoneal cavity and he had a low suspicion because he thought he knew very well
19 where the tumor was, but once he did not find it, further investigation was required.

20 16. Respondent was asked how long the procedure lasted considering he had
21 to add the extra procedure to what he had already done and there was some difficulty
22 when he did the colostomy. Respondent testified the procedure took five or six hours,
23 but he did not know for sure. Respondent was asked if the length of the procedure and
24 his having to do two different sites increased AO's blood loss. Respondent testified as a
25 result of the second resection the blood loss was probably increased.

17. Respondent was asked if there any particular problem with AO that made him finally go on to do the colostomy. Respondent testified he did not think the colostomy had anything to do with removing the cecum, that it was totally separate. Respondent noted the second procedure was a result of his having to do a more extensive resection than was indicated even by the colonoscopy. Respondent testified AO had two tumors, a carcinoid tumor, malignant, and a colorectal cancer. Respondent noted he ended up with a very low resection in a male who typically has a very small pelvis. Respondent testified he tried to put the thing back together, and, when he was unsuccessful, elected to do a colostomy and come back and put AO together at a later date. The Board noted the inability of another physician to reverse the colostomy due to adhesions and asked Respondent if the adhesions were increased because Respondent made two separate incisions and performed two separate procedures. Respondent testified he did not think so, and he believed the adhesions referred to were in the pelvis. Respondent noted the rectal stump in the pelvis would be more pertinent tissue and the other adhesion should be dividable, but AO would still have the organs necessary for a reconstitution of the alimentary tract, even now.

18. Respondent was asked what the hurry was to perform the surgery on AO. Respondent testified AO was hospitalized, prepared, and he had a diagnosis that surgery was indicated, so there seemed to be no reason not to move forward. Respondent was asked whether there was no reason to talk to Gastroenterologist, or get the actual report, or the pathology report from the colonoscopy prior to proceeding with surgery. Respondent testified the pathology report from the colonoscopy would be meaningless because it showed AO had a villous tumor, and this is totally incorrect. Respondent testified in hindsight it would have been wise to get all of the information before proceeding with the surgery.

1 19. The standard of care required Respondent to identify preoperatively the
2 portions of the colon to be removed.

3 20. Respondent fell below the standard of care because he did not
4 preoperatively identify the portions of the colon to be removed and he removed the
5 cecum of the patient when the cancer was in the sigmoid colon.

6 21. AO was subject to potential harm because he was exposed to potential
7 anastomotic leaks and other complications of colon resection.

8 **CONCLUSIONS OF LAW**

9 1. The Arizona Medical Board possesses jurisdiction over the subject matter
10 hereof and over Respondent.

11 2. The Board has received substantial evidence supporting the Findings of
12 Fact described above and said findings constitute unprofessional conduct or other
13 grounds for the Board to take disciplinary action.

14 3. The conduct and circumstances described above constitutes unprofessional
15 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might
16 be harmful or dangerous to the health of the patient or the public."

17 **ORDER**

18 Based upon the foregoing Findings of Fact and Conclusions of Law,

19 IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for
20 failure to locate the patient's tumor resulting in the unnecessary removal of healthy tissue.

21 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

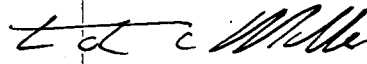
22 Respondent is hereby notified that he has the right to petition for a rehearing or
23 review. The petition for rehearing or review must be filed with the Board's Executive
24 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
25 petition for rehearing or review must set forth legally sufficient reasons for granting a

1 rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days
2 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
3 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
4 Respondent.

5 Respondent is further notified that the filing of a motion for rehearing or review is
6 required to preserve any rights of appeal to the Superior Court.

7 DATED this 9th day of June, 2005.

9 THE ARIZONA MEDICAL BOARD

10
11 By 
12 TIMOTHY C. MILLER, J.D.
Executive Director

13 ORIGINAL of the foregoing filed this
14 9th day of June, 2005 with:

15 Arizona Medical Board
16 9545 East Doubletree Ranch Road
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing
19 mailed by U.S. Certified Mail this
20 9th day of June, 2005, to:

21 Dan Cavett
22 Cavett & Fulton, P.C.
23 6035 East Grant Road
24 Tucson, Arizona 85712-2317

25 Executed copy of the foregoing
mailed by U.S. Mail this
9th day of June, 2005, to:

Robert J. Guerra, M.D.
Address of Record

